TRICARE® for Life **Mental Health** Authorization Request Form
Register to Submit Online at www.TRICARE4u.com
-OR-
Fax to 608-301-3226 (do not send more than one patient per fax)
2 Page Form Must be Completely Filled Out to Receive a Review
Direct Questions to Customer Service at 866-773-0404

Outpatient Provider Information - For Outpatient Psychotherapy Only

Individual Outpatient Provider: _____

Individual Outpatient Provider Address: _____

City:_____ State: _____ Zip Code: _____

Individual Outpatient Provider Tax ID and NPI: _____

Contact Person:_____ Telephone Number and Extension: _____

Fax Number: _____ E-mail Address: _____

Inpatient Facility Information

Facility: _____

Facility Address: _____

City:_____ State: _____ Zip Code: _____

Facility Tax ID and NPI: _____

Contact Person:_____ Telephone Number and Extension: _____

Fax Number: _____ E-mail Address: _____

TRICARE® for Life does not require or issue authorizations if TRICARE® for Life is not Primary

Patient Information

TRICARE 9 Digit Veteran Sponsor Number:_____ Veteran Name:_____

Patient Name:_____ Patient Date of Birth:_____

Patient Address:_____

Will another insurance/Medicare be paying towards this service? ☐ Yes ☐ No

Name of Insurance/Benefit:_____

Page 2 Must be Completed for an Authorization Review

Check Requested Service - If inpatient, enter estimated length of stay

☐ Outpatient Psychotherapy	
☐ Inpatient Psychiatry	Estimated # of Days:_____
☐ Psychiatric Intensive Outpatient Program (IOP)	Estimated # of Days:_____
☐ Substance Use Disorder Intensive Outpatient Program (IOP)	Estimated # of Days:_____
☐ Partial Hospitalization Program (PHP)	Estimated # of Days:_____
☐ Inpatient Detox	Estimated # of Days:_____
☐ Chemical Dependency Rehabilitative Services	Estimated # of Days:_____

Complete Treatment Plan if Outpatient Psychotherapy Only - if CPT code is not listed, an authorization is not required

CPT Code	Treatment	Begin Date for Authorization	Number of Sessions	Duration (26 weeks max)
90832	30 min with patient and or family member			
90833	30 min with patient and/or family with evaluation and management			
90834	45 min with patient and/or family member			
90836	45 min with patient and/or family member with evaluation and management			
90837	60 min with patient and/or family member			
90838	60 min with patient and/or family member with evaluation and management			
90847	Family conjoint			
90853	Group Psychotherapy - not family			

Progress in Treatment: ☐ Improved ☐ Little or No Progress ☐ Regressed Due to New Stressor ☐ Near Completion

Explain lack of progress in treatment and changes made to treatment plan to address this need:

What type of treatment are you rendering? (CBT, etc.):

Treatment goals/expected outcomes for this request:

Check All Associated Symptoms (must complete)

☐ Anger/Aggressiveness	☐ Hallucinations	☐ Non-compliance w/Treatment	☐ Severe Mood Swings
☐ Decreased Energy	☐ Hopelessness/Helplessness	☐ Obsessions/Compulsions	☐ Sleep Disturbance
☐ Delusions	☐ Impulsivity	☐ Paranoia	☐ Somatic Complaints
☐ Danger to Self/Others	☐ Insight/Judgement Problems	☐ Poor Concentration	☐ Substance Abuse

Explain how the mental health diagnosis impacts patient's ability to function (must complete):

Provider Name (print):_____

Provider Signature:_____

Credentials:_____ Date:_____

Inpatient Mental Health Requests Must Attach The Following:

Admitting Psychiatric Evaluation Physician Orders Physician Progress Notes History and Physical Discharge Plan

For Additional Inpatient Days, Send This 2-Page Form And The Following Only:

Estimated Length of Stay Current Physician Orders Last Four Days of Physician Progress Notes New Plan For Discharge